

34723

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED NOV 8 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 4317

Registrar's No. 37

1. PLACE OF DEATH:

(a) County MADISON

(b) City or town MEXQUEND, MO  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Madison

(c) City or town Marion 6200  
(If outside city or town limits, write "RURAL.")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs ELLON R CASSIDY

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 5-10-1862  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>5</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace APPROXON, MO 0  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business \_\_\_\_\_

12. Name F - WOLBY

13. Birthplace CANY-SH, MO 9  
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH PINKLOIN

15. Birthplace MO 0  
(City, town, or county) (State or foreign country)

16. (a) Informant John F Hughes

(b) Address Marion MO

17. (a) BURIAL (b) Date thereof 10-29-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEXQUEND, MO

18. (a) Signature of funeral director E. H. ...

(b) Address Marion MO

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 28  
year 1944 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 15th  
44 to Oct 28th 44  
that I last saw her alive on Oct 1st 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis, S. Mo  
Chronic Interstitial Nephritis

Due to \_\_\_\_\_

Other conditions Senility  
(Include pregnancy within 3 months of death)

Major findings: no 13

Of operations no

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature D. S. ... (M. D. \_\_\_\_\_)

Address Marion MO Date signed 10/28/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2  
43  
7-39  
X35697

RECEIVED

District Health Officer No. 4  
District File Number 1144-4501  
Date Filed 11-6-44

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 266 Primary Registration District No. 4367

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Madison  
(b) City or town Marquand  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Ellen J. Cassidy  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced w  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 18 1886  
(Month) (Day) (Year)

8. AGE: Years 44 Months 5 Days \_\_\_\_\_ (Less than one day) \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) Oct 29 1944 (b) S. C. Slaughter  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct Day 28 Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Ray A. Schuman

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